United Nations ST/IC/2018/27

Secretariat

7 November 2018

Information circular

To: Members of the staff

From: The Assistant Secretary-General for Human Resources Management

Subject: **Review of staff claims for dependency benefits for 2017**

1. The entitlement to dependency benefits is established in staff rule 3.6 and implemented under administrative instruction ST/AI/2018/6, entitled "Dependency status and dependency benefits". The purpose of the present circular is to inform staff members who were in receipt of dependency benefits in 2017, of the manner in which the review of their 2017 dependency benefits will be conducted, as well as the timelines for the exercise.

2. For ease of reference, annex I contains details on the types of dependency benefits, annex II contains contact information, and annex III contains details on the documentation required for the continuation of benefits.

I. Review of dependency benefits using the Umoja annual declaration form and timeline for the review

3. The 2017 review of dependency benefits will be conducted in Umoja using the annual declaration form, which will be available to staff on 15 November 2018.

4. The 2017 Umoja declaration form contains the information on personal status and the recognized dependants of each staff member as at 31 December 2017. Staff members are requested to review the information carefully. If the data are correct, they must certify the accuracy of the information contained in the form and supply relevant additional information, including the answer to the question regarding the amount of dependency benefit in the form of a government grant received for each child, if applicable. If the data are incorrect, they will be given the opportunity to correct the data before submitting the certification. Depending on the benefit received, supporting documentation may also be required (see sect. II and annex III for details).

5. Staff members in receipt of dependency benefits for 2017 will receive, by email from the Office of Human Resources Management, instructions on how to access their annual declaration form in Umoja on the day on which the review begins.

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6. Upon receipt of the instructions, staff members who have a dependant recognized by the United Nations shall review their dependency data for 2017 in the Umoja employee self-service module and electronically submit the certification and supporting documentation as soon as possible, but no later than 14 January 2019. The link in Umoja will be deactivated after this date.

II. Supporting documentation

7. In order to confirm continued eligibility to receive certain dependency benefits, supporting documentation may be required.

8. **Documentation not required**. No documentation is required for the continuation of dependency benefits for the following dependants:

(a) An unemployed spouse; or

(b) A dependent child under the age of 18 residing with the staff member and not receiving dependency benefit in the form of a government grant.

9. **Documentation required**. To verify a staff member's entitlement to dependency benefits, and to establish the staff member's continued entitlement to such dependency benefits, documentation in support of the entitlement is required from the staff member for any dependants not mentioned under paragraph 8 above. See annex III to the present circular for a summary of the documentation required in support of a staff member's entitlement to dependency benefits.

10. **Obligation to retain original documentation**. Staff members must retain all required original documentation in support of an entitlement to dependency benefits for a period of five years and must be ready to provide that documentation to the Office of Human Resources Management or the Office of Internal Oversight Services upon request, within 30 days, for monitoring purposes (see annex III). Failure to do so will result in the immediate recovery of moneys and the discontinuation of benefits and could result in disciplinary action.

11. Staff members are required to submit the necessary documentation in support of an entitlement to dependency benefits using the annual declaration form. Partial documentation is not acceptable and may result in the immediate recovery of moneys and the discontinuation of benefits and could result in disciplinary action.

12. When evidence of support payments is necessary, the following will be considered as acceptable proof of payment: cancelled (i.e. paid) cheques, money order receipts, wire transfer receipts and original records of bank transactions, including printouts of online bank transfer receipts. Cash transactions are not considered to be acceptable proof of support. Payments or transfers made to another party or person will not be accepted, except for cases where transfers are made to a legal guardian.

13. The submission of forged documents, the making of a false certification of the information contained in the annual declaration form or a misrepresentation of facts relating to a claim for dependency benefits may lead to the initiation of a disciplinary process and the imposition of disciplinary measures.

III. Recoveries and overpayments

14. Dependency benefits will be discontinued and overpayment recovered in accordance with section 3 of administrative instruction ST/AI/2009/1 when a staff member does not submit the annual declaration form and any requisite documentation by the deadline of 14 January 2019. Before the recovery of any overpayment, staff

members will be advised in writing of the decision to recover the overpayment and of the reasons therefor. Recovery will be made through deductions of 20 per cent of the staff member's net monthly salary until such time as the full amount is recovered. In instances where the duration of the staff member's contract does not allow for a deduction at as low a rate as 20 per cent, the overpayment will be deducted at a monthly rate that is sufficient to recover the full amount by the expiration date of the contract.

15. Staff members are reminded that, in addition to discontinuation of dependency benefits, non-compliance with the submission deadline may also result in a determination that the claimed individuals are no longer dependants, which could have an impact on the continuation of other benefits, including the G-4 visa, education grant, education grant travel and home leave travel. It is therefore imperative that staff members complete the annual declaration form by the deadline of 14 January 2019.

IV. Adding dependants retroactively

16. In accordance with staff rule 3.17, staff members are reminded that, if they have not been receiving an allowance, grant or other payment to which they are entitled, they shall not receive retroactively such allowance, grant or payment unless they have made a written claim within one year following the date on which they would have been entitled to the initial payment. In this regard, staff members wishing to add dependants may do so by submitting the required original supporting documentation to their respective human resources partners and submitting an electronic request through the Umoja employee self-service module. For more details on the required supporting documentation for request or continuation of the benefit, see annex III.

Annex I

Types of dependency benefits

1. The conditions for the recognition of a 2017 dependency benefit for a spouse, child or children or secondary dependant of the staff member are set out in staff rule 3.6 (a) and in administrative instruction ST/AI/2018/6. Effective 1 January 2017, new dependency allowances were introduced and different eligibility criteria were approved for certain types of dependency allowances. A summary of the main changes and the policy references on eligibility are included below for ease of reference.

Dependent spouse

2. A spouse is recognized as a dependant in 2017 when the spouse's gross earnings, if any, do not exceed the limit established for this purpose as set out in staff rule 3.6 (a) (i) and in section 2 of administrative instruction ST/AI/2018/6. Staff members are advised that, as at 1 January 2017, the criterion for determining what constitutes annual gross earnings for purposes of spouse allowance has changed. All earnings received, including but not limited to pension income, such as retirement and disability benefits, and earnings resulting from investments, shall be included in the computation of the annual gross earnings.

3. For staff members in the General Service and related categories and the National Professional Officer category, the earnings limit for 2017 is the lowest entry level of the General Service gross salary scale in force on 1 January 2017 for the closest United Nations duty station in the country of the spouse's place of work.

4. For staff members in the Professional and higher categories and staff members in the Field Service category, the earnings limit in 2017 for the spouse's annual gross earnings is the higher of:

(a) The lowest entry level of the General Service gross salary scale in force on 1 January 2017 for the closest United Nations duty station in the country of the spouse's place of work; or

(b) The gross salary for the lowest entry level in force on 1 January 2017 at the base of the salary system (G-2, step I, for New York).

5. In New York, the earnings limit for 2017 was $41,161 (gross salary in effect on 1 January 2017 for a staff member at the G-2, step I, level).

Dependent child or children

6. Effective 1 January 2017, dependency allowance(s) for a dependent child or children for staff in the Professional category and above and in the Field Service category are paid as flat sums, except for staff who were in receipt of salary at the dependency rate in respect of their first dependent child on 31 December 2016, who will receive a transitional allowance for this dependent child. The conditions for the payment of a dependency benefit for 2017 for the dependent child or children of the staff member are set out in staff rule 3.6 (a) (ii) to (iv) and in sections 3 and 7 of administrative instruction ST/AI/2018/6.

7. Dependency benefits for 2017 for a child or children with a disability will be paid in accordance with the provisions set out in section 5 of administrative instruction ST/AI/2018/6.

Dependent child allowance in the case of a single parent

8. For staff members in the Professional category or above and in the Field Service category, a new single parent allowance was introduced effective 1 January 2017. The conditions for the payment of the single parent allowance in 2017 are set out in staff rule 3.6 (b) (ii) and section 4 of administrative instruction ST/AI/2018/6.

Secondary dependants

9. The conditions for the payment of a 2017 dependency benefit for a secondary dependant of the staff member are set out in staff rule 3.6 (a) (v) and section 6 of administrative instruction ST/AI/2018/6. When a secondary dependant is recognized, a benefit will be paid at the rate determined by the General Assembly for staff in the Professional and higher categories and in the Field Service category. For staff in the General Service and related categories in New York, the allowance will be paid in the amount set out in the local salary scales, as periodically revised. For other duty stations, if applicable, the allowance will be paid in the amount set out in the local salary scales that are established for each duty station.

Annex II

Contact information

1. Staff members who are required to submit documentation in support of an entitlement to dependency benefits for 2017, or who have any questions regarding dependency benefits or the annual declaration form, should contact their respective human resources partners, as designated for each department or office, by telephone or email.

2. If you are unsure who your human resources partner is, please contact your local human resources office. For New York, please refer to the Umoja UNHQ support page (https://iseek.un.org/department/unhq-umoja-information), where you can find the list of all human resources partners and walk-in hours and location.

3. For all technical enquiries about using the annual declaration form in Umoja, please submit an iNeed ticket if your employee/manager self-service (ESS/MSS) focal point is unable to resolve the issue.

Annex III

Required documentation for dependency benefits

The following table contains a summary of the documentation required as evidence of a staff member's entitlement to dependency benefits:

1. For a spouse with no earnings and claimed as a dependant	No additional documentation is required. However, the staff member will be required to certify that the spouse was unemployed for the period under review (2017) and that the spouse did not have earnings from other sources, including pension income, such as retirement and disability benefits, or earnings resulting from investments.
2. For a spouse with earnings and claimed as a dependant	Proof of gross earnings: all W-2 forms (residents of the United States of America), tax returns or original statements of earnings from all the spouse's employers, as well as pension income, such as retirement and disability benefits, and earnings resulting from investments, shall be included in the computation of the annual gross earnings.
3. For every child claimed as a dependant	An original birth certificate must be presented when the child is claimed as a dependant for the first time.
(a) If in receipt of the child allowance, for a child under the age of 18 residing with the staff member	No additional documentation is required.
(b) For a child (natural or legally adopted) not residing with the staff member or with the other parent (except as provided in paragraph (c) below)	Proof of all payments made directly to the child or to the child's legal guardian for the required amount during 2017, in the form of cancelled (i.e. paid) cheques, money orders or wire transfer receipts or records of bank transactions. The amount of support should be at least equal to the amount of the child dependency benefit received from the Organization. In addition, in the case of minor children, a notarized affidavit from the legal guardian must be provided attesting to the legal guardianship of the child, that the child resides with the legal guardian and that the staff member is providing continuous support for the upkeep of the child. Cash transactions are not considered acceptable proof of support, nor is any payment made to or through a third party.
(c) For a child of a staff member who is not the custodial parent or who has joint custody of the child	The original or certified copy of the divorce decree or other court document specifying the amount of child support to be paid by the staff member, plus proof of payment in the year concerned in the form of cancelled (i.e. paid) cheques, money orders or wire transfer receipts or records of bank transactions. Cash transactions are not considered acceptable proof of support, nor is any payment made to or through a third party. The amount of payment to be eligible for a child dependency allowance should be at least the amount of the court-ordered child support, or the amount of the child dependency benefit received from the Organization, whichever is higher.

	In the absence of a court document, an original notarized affidavit from the custodial parent must be provided attesting that the staff member provided continuing support and specifying the amounts paid during 2017, together with the proof of payment described in the initial paragraph.
(d) For a child between the ages of 18 and 21[a]	Staff members who were not in receipt of an education grant should submit an original completed form P.41/B (certificate of school attendance) for the academic years 2016/17 and 2017/18. Where the academic year coincides with the calendar year, form P.41/B should be submitted for 2017. No additional documentation for proof of full-time school attendance is required for a child for whom the staff member received an education grant for the academic years 2016/17 and 2017/18.
(e) For a child of a staff member who is in receipt of a government grant	Original government assistance documents reflecting the amounts received each year.
4. For a single parent	Provide all documentation required for each child as set out in paragraphs 3 to 3 (e) above, as applicable, for each child. Additionally, proof of the status of the staff member must be submitted if not already on file (for example, divorce decree, death certificate of former spouse, certificate of legal separation or similar legal documents).
5. For a secondary dependant who resides with the staff member	Staff member's certification of support, provided on the annual declaration form, is needed. For a secondary dependant who resides or comes to reside with the staff member in 2017, proof of residency needs to be submitted.
6. For a secondary dependant who did not reside with the staff member[b]	Proof of all payments made directly to the secondary dependant for the required amount during 2017, in the form of cancelled (i.e. paid) cheques, money orders or wire transfer receipts or records of bank transactions. Cash transactions are not considered acceptable proof of support. The secondary dependant must be reflected as the recipient on all proof of payment. The staff member must provide one half or more of the secondary dependant's support and, in any case, at least twice the amount of the secondary dependency allowance.

[a] Dependency status is recognized through a period of vacation between academic years when the child enrols for full-time attendance during the regular academic year. Otherwise, the dependency status ceases on the last day of full-time attendance at the educational institution. The required forms are available on iSeek (https://iseek-newyork.un.org/webpgdept593_53) or from your human resources partner in the Office of Human Resources Management or local human resources offices.

[b] At the time of establishment of an entitlement to a benefit for a secondary dependant, staff members should submit in person their own birth certificate, as well as the birth certificate or passport of the secondary dependant, with an original, completed form P.85 and proof of support as stated above. Please note that the birth certificates and/or passport must be original or certified true copies.

United Nations ST/IC/2018/27/Corr.1

Secretariat

6 December 2018

Information circular

To: Members of the staff

From: The Assistant Secretary-General for Human Resources Management

Subject: **Review of staff claims for dependency benefits for 2017**

Corrigendum

Annex I, paragraph 5

For the existing text *substitute*

5. In New York, the earnings limit for 2017 was $41,461 (gross salary in effect on 1 January 2017 for a staff member at the G-2, step I, level).

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United Nations ST/IC/2018/28

Secretariat

17 November 2018

Information circular*

To: Members of the staff

From: The Assistant Secretary-General for Human Resources Management

Subject: **Membership of the New York General Service Classification Appeals Committee**

1. The purpose of the present circular is to inform the staff that the membership of the New York General Service Classification Appeals Committee is as follows:

Chair: Maha El-Bahrawi

Members representing the Administration:

Adrienne Palacios
Jocelyne Sery

Members representing the staff:

Patricia Neneth
Chandana Mutucumarana

Secretary: Elza Maharramova

Alternate Secretary: Olakunle Adeyemi

2. The terms of reference of the Committee are set out in section 7 of administrative instruction ST/AI/1998/9 and ST/AI/1998/9/Corr.1.

* The present circular, which supersedes ST/IC/2017/30, will be in effect until further notice.

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United Nations ST/IC/2018/29

Secretariat

20 November 2018

Information circular*

To: Members of the staff at Headquarters

From: The Assistant Secretary-General for Human Resources Management

Subject: **Regulations, Rules and Pension Adjustment System of the United Nations Joint Staff Pension Fund**

The purpose of the present circular is to inform staff of the Regulations, Rules and Pension Adjustment System of the United Nations Joint Staff Pension Fund effective 1 January 2018 (https://www.unjspf.org/regulations-and-rules-of-the-unjspf/).

* The present circular will be in effect until further notice.

18-20027 (E) 231118

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United Nations ST/IC/2018/30

Secretariat

20 November 2018

Information circular*

To: Members of the staff at Headquarters

From: The Assistant Secretary-General for Human Resources Management

Subject: **Navigating the health-care system in the United States of America**

The purpose of the present circular is to inform staff of the handbook entitled "Navigating the health-care system in the USA" (see annex).

* The present circular will be in effect until further notice.

18-20030 (E) 271118

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Annex

Annex I

MEDICAL SERVICES DIVISION

NAVIGATING THE HEALTH CARE SYSTEM IN THE USA

November 2018

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Foreword

I am very pleased to present this Handbook, which will be useful to you as you and your family transition into New York.

Access to health care can be one of the most daunting parts of moving to a new duty station. Even when the quality of care available is high, navigating the health system, dealing with insurance and working out which practitioners to see can all be quite overwhelming.

This Handbook aims to simplify some of that, and gives you the information you need to make informed choices. I encourage you to read it prior to taking up your post, so that you are equipped to make decisions about health care for you and your family.

The UN invests heavily in supporting the health and wellbeing of its staff through our health insurance products, and the Medical Services Division. We want you to feel confident and at ease as you learn to use the US health care system.

You are going to have a very busy first few weeks as you settle into your new duty station. Don't forget, during this time, to make some space to start taking control of your health care. I recommend you attend to three key tasks:

1. If your new role is going to involve travel, make an appointment at the Medical Services Division to have your travel health needs met (especially vaccinations), well in advance of your first planned travel.
2. Make a routine appointment with a Primary Care Practitioner *(this Handbook includes information on how to choose one)* within the first couple of months, so that you can start familiarising yourself with the health care system here, without the pressure of a medical emergency.
3. Identify your nearest emergency departments, and in that first discussion with your Primary Care Practitioner, develop a plan about who you would call, and where you would go to, in the event of an injury or sudden illness.

If you do become unwell or suffer an injury, I know that the information provided here will help you to navigate the health care system with ease.

I wish you health and success in New York.

Martha Helena Lopez
Assistant Secretary-General
Office for Human Resources Management

Introduction

The health care system in the United States (US) can be confusing with its insurance plans, payment systems, coverage options and forms of medical practice. This Handbook aims to give you a general overview of the system, and help you navigate the often-convoluted pathways to obtaining health care in the US.

What you receive in health care benefits in the US is determined by the insurance package that you sign up for. Health insurance in the US resides primarily in the private sector, where employee groups negotiate with private health insurance companies to manage a package of health care benefits for their employees. In any large employee group there might be one, two or three health care packages offered, each with different benefits and, to some extent, different costs for the employee. The United Nations (UN) provides its own insurance package and contracts to process in- and out-of-network insurance claims in the US with three different insurance companies: Aetna and Empire Blue Cross (EBC) for medical, and Cigna for dental. This booklet primarily refers to protocols and benefits associated with the two medical insurance packages, Aetna and Empire Blue Cross (EBC), offered to UN employees. The major concepts outlined here are applicable to the dental insurance plan as well.

It is important to note that the UN insurance plans are self-insured plans. This means that the risk of providing insurance rests with the UN and the covered members under the plan, not with the insurance carriers. Premiums are set based on the projected claims experience of all active and retired staff members covered under the plans, and do not take into account the claims experience of non-UN populations. Premiums collected are held by the UN, and the insurance carriers are reimbursed only for the claims that they actually pay out to providers and plan members, in addition to a fixed monthly administrative fee per subscriber (i.e., an active or retired staff member, regardless of the number of family members covered).

While health insurance provides assistance to staff in covering a variety of medical costs, it does not cover all medical-related services, nor at full costs. All staff members and their covered family members should familiarize themselves with the rules and benefits of their selected health insurance plans, which are contained in the latest information circular and plan descriptions available on the UN Health and Life Insurance Section's website (un.org/insurance).

Terminology

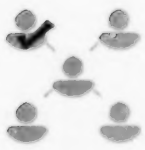
Co-Pay is a fixed fee established by the insurance companies in advance, which you make each time you use a service. It is paid at the time of each visit or may sometimes be billed to you at a later date. It is customary that the co-pay for a visit to a primary care physician to be lower than that for a specialist. The amount is often listed on your insurance card.

Deductible refers to medical expenses that you will be asked to pay before your insurance covers to pay for a service.

For example, some plans require consumers to pay for anywhere from $20 to $1,000 worth of services before the insurance coverage will start paying any benefits.

Factors to Consider:

- Deductibles are mostly applied to out-of-network services.
- A deductible can also be applicable for certain kinds of services, such as hospitalizations and mental health services.
- It is important to know what payments count toward your deductible.
- It is best to keep a file of receipts for the out-of-pocket expenses incurred, as well as statements showing what your insurance company has paid. This will help you to keep track of expenses and allow you to more easily keep track of where you and your family are in paying your deductible.
- Even if you do not expect to receive a reimbursement, it is still important to file a claim with your insurance company in order for these expenses to be tracked and credited towards your deductible.



In-Network refers to doctors, hospitals, clinics, laboratories, pharmacies and other health care providers that insurance companies have negotiated with to provide health care services at an agreed upon rate of payment.

For example, a routine visit might be negotiated at $50/visit, which means the doctor agrees to accept this rate of payment, with the patient paying his/her co-pay and the insurance plan covering the balance.

Factors to Consider:

- With the exception of co-pays, the insurance plan pays for the services.
- You should not incur additional out-of-pocket expenses for covered services or prescription drugs that are provided in-network.

Out-of-Network refers to medical service providers who are covered by your plan but are not signed on as in-network.

How it works: Your insurance company agrees to pay 80% of what they have determined to be the "usual and customary" fee for the service. You will pay out-of-pocket for the remaining portion.

Factors to Consider:

- Whilst going out-of-network may mean that you have a wider range of providers to choose from, the downside is that you can incur much higher (and sometimes, very significant) out-of-pocket costs. The out-of-network provider often charges a much higher fee than an in-network provider.
- Out-of-network expenses can be considerable if the services are for surgery, hospitalization, and other costly procedures.
- It is perfectly acceptable to ask for the standard charges for a visit, a medical procedure or a diagnostic procedure in advance when you are going out-of-network. It is strongly advised that you find out which costs you will be responsible for in advance i.e., the facility costs, anaesthesiology, medications, etc.
- An additional drawback of out-of-network services is that you need to assume much more responsibilities for the administration of your medical care. Referrals, billing, prior approvals and cost management for out-of-network services require attention and input from the patient.
- Given the high cost of health care in the US, it is important for individuals to understand that they put themselves at financial risk when utilizing out-of-network providers since the insurance plans' reimbursements are based on maximum allowable amounts and not the actual amounts charged by providers.
- Out of network providers drive up the costs of insurance premiums

Out-of-Pocket Costs is a generic term for any medical expenses that you, the consumer, are required to pay on your own. These are expenses above and beyond what your insurance plan will pay for.

Prior Authorization is an attempt to rationalize and contain the high cost of medical care in the US. There are a number of medical procedures, medications, diagnostic tests and specialty consultations and hospitalizations that require authorization from the insurance company before the insurer will cover them. Except in emergencies, these procedures require authorization prior to the event. Your health care plan explains which health care activities needs prior authorization or approval.

Who is responsible for obtaining a prior authorization?

- If you are going to an in-network provider, they are responsible.
- If you are using an out-of-network provider, you or the physician who orders the test or performs the procedure will be responsible for obtaining approval from your insurer.

Factors to Consider:

- As the consumer, you will want to make sure that prior authorization has been obtained as you will be responsible for the entire bill if the approval is not in place.
- In some plans, failure to seek prior authorization for scheduled hospitalization, even for an in-network provider, will result in a penalty to be

deducted from what the insurance plan will reimburse. You will then be responsible for paying your provider the amount of the penalty that was not reimbursed by your plan.

- Prior approvals for services of out-of-network providers mean that the services will be reimbursed based on the maximum allowable amounts applicable for the plan; it is **not** a guarantee that the plan will reimburse at the prices charged by the provider.

How to choose an insurance plan

Your employer offers the choice of two plans: Aetna and Empire Blue Cross, and a supplementary Dental Plan from Cigna. Members of your family who work in the US may receive health insurance through their employers. There are different rules and protocols regarding health benefits so please read this section in your Handbook carefully, since there may be a cost savings if you are able to access benefits from both your plan and one in which your spouse is enrolled.

Here are some of the factors to consider in choosing a medical insurance plan:

- **Your health needs and those of members of your family**: Young families without significant chronic health issues may do well with a plan that pays primarily for in-network coverage, i.e. a health maintenance organisation or Exclusive Provider Organization (EPO). The assumption here is that your health needs are simple and can be taken care of through the plan. If it is anticipated that you or a family member will require medical care from a number of specialists, expensive medications, and/or complicated medical procedures, then a plan with more flexibility and health care options might be best for you, i.e. a Preferred Provider Organization (PPO) or one with good out-of-network benefits.

- **Cost of deductibles, co-pays, and monthly rates, and scope of coverage**: For example, does the plan cover eye glasses, hearing aids, psychotherapy, dietary counselling and alternative medicine providers? These benefits are usually listed under a section called "Schedule of Benefits" and it is recommended that you review the Schedule of Benefits section to see which plan best fits you and your family's health needs.

- **The possibility of accidents or sudden diagnosis of serious illness**: Accidents should be considered in selecting your plan, even if you and your family are generally healthy and may not need regular care. Like those of other employers, UN insurance plans have strict rules about enrolling in a plan or switching to another plan at any given time. If you are suddenly diagnosed with a serious illness or in an accident, you will not be entitled to join a plan or switch to a plan with better benefits at your convenience. Therefore, you should not only consider the monthly costs but also carefully review the plan's benefits and coverage.

* Some of these considerations will only be relevant to plans other than Aetna or EBC, while others apply to both.

Cigna Dental Preferred Provider Organization (PPO) Plan

The dental PPO programme offers a large network of participating providers in the Greater New York Metropolitan area and nationally. A dental PPO functions like medical PPO: the network of dentists who participate in the CIGNA dental PPO plan accept as payment a fee schedule negotiated with CIGNA. When covered services are rendered by an in-network provider, CIGNA reimburses the dentist according to the schedule and the participant normally has no out-of-pocket expense. One may also choose a dentist who is not a participating practitioner in the CIGNA plan. Covered dental services rendered by out-of-network providers are reimbursed as a percentage of reasonable and customary allowances. When you select a Participating Provider, this plan pays a greater share of the cost than if you were to select a non-Participating Provider.

What to expect when you visit a physician's office

Making the first appointment: When you call to set up an initial visit, you might want to ask a few questions before going forward with the conversation:

- Are they taking new patients?
- When is the first available appointment?
- Do they accept your insurance plan?
- Are they part of the network of your insurance plan? (Practices change their insurance panels without much notice, so it is always good to check.)

In most offices, staff may inquire as to the nature of your medical problem. Are you calling for a wellness examination i.e., a routine check-up, or is the problem acute and requiring an immediate appointment? If you have special needs, such as requiring an appointment within a specific time frame, let the staff know that as well. Some offices may also ask for your insurance information while making the initial appointment.

Your medical appointment: It is recommended that you arrive 10 to 15 minutes before your first appointment since you will be asked to complete paperwork that includes providing your and your family's medical history, any medications you are currently taking, any allergies, etc. You should be ready with that information. You will also be asked to sign forms regarding medical confidentiality as well as your agreement to be personally responsible for any costs that the insurance plan will not or will only partially reimburse. Some offices may also have their registration forms online, which you may complete at home and bring to your first appointment.

Offices have different routines: In some doctor's offices you will be seen initially by a medical assistant who prepares you for the visit. The medical assistant will ask you to disrobe and put on an examination gown, take your height, weight and blood pressure, and collect information about your presenting problem. In other offices, the physician may speak with you first and obtain your medical history and then ask you to go into a separate area to disrobe and put on an examination gown.[1] After the examination you will be asked to dress and the physician will speak with you about their findings and make recommendations.

It is important that you have time to ask questions: Make sure that you prepare a list of questions before your visit. You would likely have time to ask these questions during your post-examination session with the doctor. When you leave the office, you should have a clear picture of what the doctor thinks about your health picture and what is recommended as the next steps in your ongoing medical care. Are instructions for testing or follow-up plans clear and have all your questions been answered? If you are not being asked to return to the office for a follow-up visit, make sure you know how you can obtain the results of any investigations that are being ordered.

Primary Care

The primary care physician (prime or "PCP") is the cornerstone of medical care in the US. The primary care physician offers continuous and comprehensive care, helps to organize referrals to specialists, administers preventive care, and is first in the line of contact for most medical problems. Primary care physicians are general internal medicine physicians, pediatricians and family physicians who see both children and adults. Many women, particularly those of child-bearing age, receive their basic care from a specialist in women's health called an obstetrician gynaecologist (Ob-Gyn), who also provides many of the recommended preventive care services. The Ob-Gyn is not considered a primary care physician in most systems.

[1] Respect for patient privacy is a well-articulated value in the US health care system. There should be a private place for disrobing and dressing and instructions given about how much disrobing is required, e.g., outer garments, all your garments, etc. The examination gown or garments should provide adequate covering to preserve your modesty. There should be some discussion about the extent of the examination before you are asked to undress. When a male physician is examining a disrobed female patient, there is usually a female chaperone present and/or you may request one to be present.

Most insurance plans require you to sign up with a primary care doctor who manages your medical care. While both UN plans do not generally require referrals from your primary care physician to seek care from specialists, there are specific situations where a written referral would be useful; these are described in your plan's document. It is recommended you select a primary care physician who can advise you about health matters and help navigate the complexities of the US health care system.

Primary care practices are organized in many different forms and you, the consumer, have a choice of which one you want to sign up for. Before deciding, however, you should determine in advance whether they accept your insurance **and** if they are in-network or out-of-network. For example, some practices do not take insurance and require the consumer to pay out-of-pocket. If you choose this option, you are responsible for negotiating reimbursement with the insurance company.

Here are a few of the practice models:

Private practice offices: There are hundreds of private offices throughout the New York metropolitan area out of which a single physician or group of physicians provide medical services. Medical practitioners can decide to sign up with a wide array of medical plans and insurance providers, go with only a few, or none at all.

Multispecialty groups: These are private practice groups that, in addition to having primary care physicians on staff, offer a broad array of specialty services.

Community clinics: These offer another way for physicians and other medical providers to work together in comprehensive care groups. Many community clinics are subsidized by the government, which means they have to accept a broader range of insurance plans, and meet certain standards for hours of service, range of services provided, and after-hours coverage.

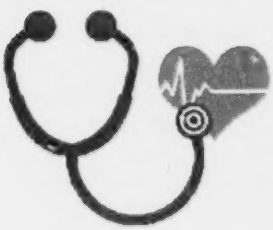
Hospital-based practices: Most hospitals in the New York metropolitan area are associated with an ambulatory (outpatient) clinic that has primary care physicians as well as specialty clinics. Most also have teaching programs that include post-graduate medical trainees as providers.

Hospital affiliated medical practices: Many of the larger hospitals in the New York metropolitan area have created networks of affiliated medical practices that extend to different boroughs and even to different states. In addition to providing primary and specialty care services, these practices refer to the parent hospital for diagnostic studies, hospitalizations, additional specialty care and/or emergency care.

Concierge medical practices: A new development in primary health care delivery is the growth of what are called concierge medical practices. Usually made up of one or more physicians, these practices charge a yearly membership fee, in exchange for more convenient and personalized services for you, the consumer. Your insurance plan is used to cover most medical expenses; the yearly membership fee ranges from $150 to $5,000 and not reimbursed by the insurance plan. This fee pays for "amenities" such as email and phone access to physicians, same day appointments, no (or short) waiting times, and online appointment scheduling. Some concierge offices take a wide range of medical insurances, while others are very limited. Most, if not all, of these concierge practices are considered out-of-network providers and claims will be reimbursed by the plan accordingly. More information about concierge practices in New York is available online.

How to find a primary care physician: A good place to start is the online site provided by your insurance company that lists all physicians who have contracted with them to be in-network providers. This listing is organized by specialty and location (borough). Primary care physicians are listed under general internal medicine, paediatricians, and/or family practice. Friends and colleagues are also a good source of referral, or you may find it convenient to locate a medical practice that is close to where you live or work. If you or family members have a complex set of medical needs, attending a hospital or hospital-affiliated practice might be the most convenient, as medical information is most easily shared within these systems. Once you have located a primary care physician, you can go online and find consumer ratings of individual physicians and other information that may help you select a primary care physician. Although changing your health insurance plan can only be done once a year during the UN official enrolment period, changing your primary care physician can be done at any time. You should not feel locked into any choice since it is very important to find a physician that you trust and with whom you feel comfortable.

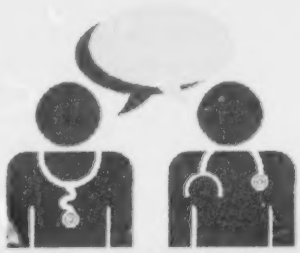
Specialist Care



The medical care system considers a specialist to be any provider other than your primary care physician; specialists can be in-network or out-of-network. While both UN plans do not generally require referrals from your primary care physician to seek care from specialists, it is recommended to get a written referral anytime you are planning a visit to any kind of specialist. This will insure that your primary care physician receives a written report from the specialist and that your medical care (and documentation of your medical history) is coordinated from one place. An exception to the referral rule is women's health, where referrals are generally not required for visits to obstetrician gynaecologists (Ob-Gyn).

While some specialty care, such as dermatology or ophthalmology, can be relatively straightforward procedures, you are advised to prepare in advance for specialty visits that address more complex medical issues. Make sure to ask your primary care physician for copies of relevant laboratory and radiological studies, a referral note, and copies of letters from all other specialists you have seen for the problem.

Finding a specialist: The best source for finding a specialist is your primary care physician, who would generally work within a network of specialists. A second source is your insurance plan, which can give you names of in-network specialists in your area. For complicated and or more serious health concerns, you may request a referral to a specialist who practices at one of the specialty hospitals – cancer, joint disease, eye and ear problems or one of the larger academic medical centres in the city – such as New York University Medical Center, Columbia Presbyterian, Mount Sinai and New York Cornell.



Second opinions: Most insurance plans allow for a second opinion when a surgical procedure is advised. If you have any questions or doubts about the need for a surgical procedure, it is your right to ask for a second opinion from another specialist in the same field. Your primary care physician can arrange for a second opinion referral. The UN's insurance plans will cover the cost of doctor's visit for a second opinion in accordance with the plan rules for in- and out-of-network visits.

Preventive Care

Preventive care is widely accepted as an essential ingredient of the US health care system. Preventive care and preventive care guidelines are highly protocolized and are based on an understanding that some medical conditions can be almost completely prevented with immunizations, a healthier diet and exercise, smoking cessation, and/or other conditions can be vastly mitigated through early detection with screenings such as mammograms, PAP smears, colonoscopies, and early interventions such a removal of premalignant polyps from the colon. Preventive care guidelines have been established by a number of expert organizations, however, there are some differences of opinion among them as to what constitutes necessary preventive care. When you visit your primary care physician and/or Ob-Gyn, they will advise you on preventive care procedures and recommended health screenings. Most health insurances cover the cost of preventative care services, and include a co-pay. These services often include

an annual physical exam, immunizations, routine obstetrician-gynaecologist exams, mammography and PSA screenings. Additional information on the preventative care services covered by your health can be accessed online:

Aetna: hr.iu.edu/benefits/pubs/misc/students-PreventiveCareCoverage.pdf

Empire Blue Cross empireblue.com/preventive-care/

Basic preventive care recommendations include:

Children: Starting in the first few months of life, there is a regular schedule of immunizations and examinations recommended for infants and children in the US. Children entering school are required by law to be immunized against common preventable diseases such as mumps, measles, chicken pox and many others. Parents should ensure to keep all documentation of their child's immunization history as they will likely be needed for school entry. Children at 11 or 12 years old should get two courses of the HPV vaccine 6 to 12 months apart.

Women and men between the ages of 50 and 75: are advised to have a screening procedure for early detection of cancer of the colon. The most common recommendation is for a colonoscopy every 10 years.

Women between the ages of 50 and 74: are advised to have a mammogram screening every two years for early detection of breast cancer.

Women between the ages of 21 and 65: are advised to have a PAP smear no more than every three years to screen for cancer of the cervix.

Adult immunizations: Diphtheria/Tetanus immunization is recommended every 10 years. Immunizations to prevent influenza (flu) and pneumonia are recommended for people over 65 years of age, and those at higher risk for medical complications due to influenza. Regardless of prior history of chicken pox, adults over 50 are advised to receive 2 doses of recombinant zoster vaccine (RSV) or one dose of zoster vaccine live (ZVL) to prevent shingles.

Smoking cessation: There have been active campaigns throughout the US over the past 10 years in support of smoking cessation If you are a smoker, your primary care physician can advise you on smoking cessation methods.

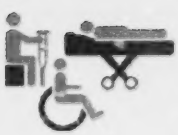
Emergency and Urgent Care

In planning for your medical care, it is recommended to learn in advance what to do in the case of urgent or emergency medical problems. There are a number of options for dealing with health problems requiring immediate attention that arise outside of your primary care physician's regular office hours.

Many primary care offices have after-hours phone coverage. During your first visit to the office, ask what kind of after-hours coverage they provide. It is always preferable to call your primary care physician's office for a consultation before you seek outside care. They may suggest you come into the office, refer you to an urgent care centre, and/or emergency room or send you directly to the hospital for admission.

Urgent care centres or walk-in centres. Urgent care centres offer an alternative to emergency room care. These centres are scattered throughout the New York metropolitan area and do not require appointments. They take a range of insurance plans, and usually have on-site x-ray and laboratory facilities. Urgent care centres can provide diagnosis and treatment for many acute medical problems without the lengthy waiting time that one often encounters in the emergency room. You may want to locate an urgent care centre in your neighbourhood, and ask in advance if they accept your insurance plan.

There are no rules for determining a true medical emergency. A sudden loss of one's capacity to speak, reason, move and/or perform ordinary life activities may be considered an emergency, as might severe pain, high fevers, large blood loss, etc. The city's emergency care system can be accessed by dialling 911. An ambulance with a trained crew of emergency medical technicians will be dispatched to your location and bring you to the nearest hospital. Most large hospitals in the New York metropolitan area have emergency rooms that serve as the entry point for people who need acute hospitalization. It is also possible to walk into a hospital emergency system on your own.



Emergency rooms are run on a triage system, i.e. the sickest patients take priority. At the entry station you will be seen by trained medical personnel who assess the urgency of your medical needs, and who track your care based on the severity of their assessment. When going to an emergency room with a non-emergent problem, it is common to wait four or five hours to access service and, depending on the time of day and/or month, experience a great deal of crowding. Urgent care centres may be a better alternative for non-life-threatening situations as they are less costly and time-consuming.

Most plans penalize members for using emergency rooms for non-emergency conditions. By only covering a portion of the service cost, which can leave you with a sizeable out-of-pocket expense, consulting with your primary care physicians' office prior to going to an emergency room is advised. If i emergency care is required, your primary care physician can inform the Emergency Room in advance that you will be arriving, which often makes for a much more efficient visit.

Women's Health Care

Women's health care can be organized through different systems. Some primary care physicians, particularly those from family practice, offer routine women's health care: PAP smears, contraceptive counselling and pregnancy counselling. Some women prefer to go to a woman's health specialist, an Obstetrician-Gynaecologist (colloquially called an "O-B-G-Y-N",) for all their women's health care and your insurance plan will cover those visits. There are also many clinics – family planning, Planned Parenthood, and others – that specialize in women's health care during the reproductive years. These clinics offer women's health services, contraceptive counselling and, in some cases, termination of pregnancy. There is a listing of these clinics in the Appendix.

Pregnancy Care: Although some family practitioners provide obstetric care, most of the obstetric care in the US is provided by women's health specialists – an Ob-Gyn and/or a midwife specializing in Obstetrics. Deliveries are performed mainly in the hospital and patients have a choice of birthing procedures: natural, with anaesthesia, or in a birthing suite. These possibilities are generally discussed in advance with the patient. There is a small movement towards home birthing in the US and these deliveries are done by midwives. As in much of US medicine, safety is a major concern. Pregnancies during the final stages are monitored closely, and if there is any sign that the birthing process is not going well, or that the unborn baby is in distress, a caesarean section or "C-section" is advised. The US has a higher rate of C-section relative to many other countries, driven by risk management practices. Expectant mothers are also advised to contact their insurance company to discuss any related benefits that may be covered by the plan.

Breastfeeding services are provided to UN members to facilitate an easier transition to work. Duty stations in New York, Geneva, Vienna, and Nairobi provide private lactation rooms with refrigerators to store milk. Other duty stations are required to provide similar services. Staff members are allowed time off during the day to express milk or breast feed if their infant is under 1 year of age. This time may be up to 2 hours if commuting or 1 hour if expressing milk. Lactation consultation and breast pumps are covered by Aetna and Empire BCBS. Visit your insurance website to find the providers and supply companies. In order to receive more information on lactation services, please refer to the UN Lactation Handbook in the HR Portal (hr.un.org).

Other Issues

Communication

There is an increasing interest in US medicine on improving communication between the doctor and the patient. Doctor-patient communication is now a regular part of the medical school curriculum and most post-graduate primary physician programs offer additional training. An informed and active patient is considered the ideal and much attention is being devoted to achieving this ideal. The expectation is that the patient and family will ask questions and can expect answers from health care providers, and patients will be active partners in making health care decisions.

Below are some of the things you can do to increase the likelihood of having a satisfying experience with your doctor. These recommendations are particularly applicable for consultations with specialists:

- **Come to the visit prepared with questions.** Think about what you want to accomplish with the visit. Many people do web research prior to a planned visit, and most physicians expect to be asked questions based on this research.

- **If you are being referred to a specialist,** ask your primary care physician why you are being referred and what questions do you want to ask the specialist. Bring all relevant laboratory and consultation reports with you to a specialist visit.

- **Bring a family member or friend with you to your medical visit.** To help process what you're learning, you may want to bring someone else with you as you may feel overwhelmed by the amount of information provided by physicians or other medical personnel. You can request to have them with you during the initial interview and post-exam discussion.

- **Ask questions.** If there is terminology you do not understand, ask for clarification. If a test is being ordered that you do not understand about, ask about it. Why is it being ordered? What does it involve?

- **Treatment recommendations.** Whether the treatment be medications, medical procedures, surgery or something else, ask about what you can expect while undergoing treatment, about possible side effects, the anticipated recovery period, and anything else that may concern you.

Language Comprehension

New York City is a polyglot culture and, to some extent, this is recognized in the medical care system. Public hospitals and clinics are required to have a panel of interpreters, or phone interpreters, available to serve non-English speaking clients. Private medical offices offer a variety of language skills. When researching a physician on the web you will find information about the languages in which a physician and/or his/her office staff is fluent. It is also permissible to bring a family member to help with translation.

Confidentiality

There is a great deal of emphasis on patient confidentiality in the US health care system. You, the patient, have the right to decide who has access to your medical information. Your written permission is required for your medical information to be sent to another doctor, medical faculty, insurance company or lawyer. Your verbal permission is required for family members, including your spouse, to be given details about your medical condition. Adolescents 18 years and older are considered emancipated and enjoy the same right to confidentiality as other adults in the family. There are specific situations such as family planning and treatment for Sexually Transmitted Diseases (STDs) where adolescents under the age of 18 can request confidentiality for their medical treatment.

Electronic Medical Records

The Electronic Medical Record (EMR) is a digital system used by hospitals and clinics to store secure health-related information. The EMR allows physicians and health care providers to access their patients' medical history in an efficient manner. Any health care providers assigned to your care has access to these records. All information in the EMR is confidential and protected by the Health Insurance Portability and Accountability Act (HIPAA). You may request a copy of your medical records if desired.

Patient Portals

There is an increasing use of patient portals in US hospitals and clinics. Patient portals are secure websites where you may access your personal health information. After setting up a secure username and password, you can access information on your recent visits, laboratory results, and medications. Some patient portals allow you to communicate directly with the provider or clinic through secure online chat services. This provides you with the opportunity to ask questions on your care or request for medication refills. Additionally, you may fill out online forms prior to your visit to save waiting time. All information in patient portals are secure and protected by HIPAA.

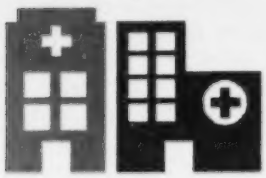
Advance Directives and Living Wills

All patients have the right to make decisions regarding end-of-life care. These decisions are codified under the term, "advance directives." Elements of advance directives include:

- **Living will**: This legal written document spells out the types of medical treatments and life-sustaining measures, such as mechanical breathing (respiration and ventilation), tube feeding or resuscitation; you want or do not want. In some states, living wills may be called Health Care Declarations or Health Care Directives.
- **Medical or health care Power of Attorney (POA)**: The medical POA is a legal document that designates an individual – referred to as your health care agent or proxy – who can make medical decisions for you in the event that you are incapacitated. However, a medical POA is different than a Power of Attorney that authorizes someone to make financial transactions for you.
- **Do not Resuscitate (DNR) order**: This is a request to not have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing.

Some people feel that it is helpful for everyone, regardless of health status, to have advance directives. Others consider them relevant only when a medical situation arises during which they might be required. On admission to the hospital, most people are asked to name a health care proxy or POA, and sign for other directives. Elderly patients are all encouraged to have advance directives and your doctor's office may ask you if you have them.

Hospitalization

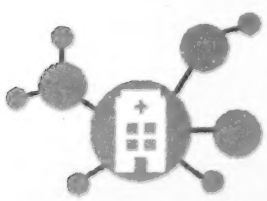


For most people, hospitalization is a significant life event. Hospital rules and protocols disturb our life rhythms and daily habits. The food is generally not to our taste and sleep is interrupted. If you are in the hospital, however, chances are you really need to be there. There has been a trend in US health care to limit hospitalizations, and the time one spends in the hospital. Many surgical procedures are now performed in an ambulatory outpatient setting, which means you check in on the day of surgery, have the surgery, and return home the same day.

Hospitalization stays have also become quite abbreviated. For example, the standard hospitalization for a normal childbirth is 24 to 48 hours and 96 hours post-caesarean section. Limiting these stays has proven to be a health benefit as recovery and rehabilitation are most effectively carried out away from the disruptive rhythms of the hospital. If it is not feasible to have what you need for recovery in your home, there are rehabilitation units at most hospitals where people can stay for a limited period. Your plan provides coverage for a rehabilitation unit stay and/or some level of post-hospital discharge home care if it is medically necessary.

Hospital admissions are arranged by a physician, and which hospital you enter is determined by your admitting physician. For example, a surgical procedure will be scheduled at a hospital chosen by the surgeon. In the case of an emergency, you will be taken to the nearest hospital and, if hospitalization is required, you will be admitted to that hospital and assigned a physician if your primary care physician is not on their staff. Most hospitals in the New York metropolitan area are teaching or training hospitals, so you will be visited by many different levels of physician providers. Expect to be asked frequently to give your name and birthdate by every provider you encounter. This preoccupation with patient identification is part of an entire system developed to prevent medical errors. If it is not clear to you or your family which physician is in charge of your care, it is important to ask for their name and contact number, so that you can request copies of your hospital record to be sent to your primary care physician. Upon discharge, you will be given a discharge summary that lists prescribed medications and follow-up recommendations.

Hospitals here generally have their own visitation rules and guidelines, including specific visitation hours and limits on the number of visitors a patient can receive at any one time. Most hospitals here do not permit visitors to sleep or stay overnight in the patient's room, unless specifically authorized.



Your plans reimburse 100% of hospitalization costs when your care is provided in-network, and coverage is for a semi-private room. If you are taken to an out-of-network hospital due to an emergency, most plans will reimburse for the full cost of care. Make sure to check your medical insurance plan.

Prescription Drug Coverage

Medications or prescription drugs

Medications can be a major contributor to your medical expenses. Although both UN insurance plans offer prescription drug benefits, there are a few things to know about medications, and prescribing in the US, that may help reduce out-of-pocket costs.

Over-the-counter versus prescription medications: Your prescription drug benefit applies only to those medications that are prescribed by a licensed provider. You can buy many medications for pain, colds, stomach problems, etc., as well as vitamins and supplements, without a prescription (often referred to as "over-the-counter"). However, these costs will not be reimbursed under your pharmacy benefit plan.

Generic drugs: Many of the commonly used medications, antibiotics, hypertension, and heart disease medicines are available in generic form. Generic medications are highly regulated in the US and most are equivalent in strength and quality to brand name medications. Your prescription drug benefit offers the best coverage (the least out-of-pocket costs) when generic medications are used. Most US doctors will prescribe generic drugs if available. If you choose a branded drug instead, you will be responsible for the price difference. Choosing to use generic medicine is an important contribution to keeping insurance costs affordable.

In-network and out-of-network: Pharmacies are also in-network and out-of network. Your drug benefit gives the best coverage when an in-network pharmacy is used.

Mail order: The insurance plans also have contracts with mail order pharmacies that will issue a 90-day supply of medications to you, the patient, at considerable cost savings. Mail order prescriptions are most effective for chronic or long-term medications. Remember to ask your physician to write a prescription for a 90-day supply of medication when you plan to use an in-network mail-order pharmacy.

Prior approvals: Certain medications like for cancer treatment, transplantations, or rare blood diseases, are highly specialized and have no generic alternatives. "No generic alternatives" mean they are expensive and generate high out-of-pocket costs. The cost of these medications can be substantially reduced if your physician requests a "prior approval" from your insurer and makes the case for a lower cost since there is no substitute available for the medication.

Special Concerns

Mental Health Problems

Mental health care in the US, also referred to as behavioural health, is organized quite separately from your other healthcare systems and may be difficult to access without some guidelines. Within the mental health system there is a strong bias toward psychopharmacology, and many psychiatrists in the US limit their practices to diagnosing and prescribing psychiatric medication. They are called psychopharmacologists. Therapy, counselling or medication for emotional problems is very common in the US and seems to carry fewer stigmas than in other cultures.

Below are some guidelines for using the mental health care system:

- **If you are faced with a mental health emergency**: such as marked changes in behaviour and/or thought processes not related to an acute physical illness or medications, there are a number of hospital-based psychiatric emergency rooms throughout the metropolitan area where you or family members can be seen for evaluation and, if needed, be admitted to a psychiatric facility for in-patient treatment. There is a list of hospitals that have psychiatric emergency facilities in the index. If you or a family member is experiencing a marked change in emotional behaviour or has an existing mental health problem, it is advisable to access this type of psychiatric emergency facility rather than a regular emergency room where personnel are trained to respond to psychiatric emergencies and can make appropriate decisions about follow-up care).
- **Ongoing psychiatric or psychotherapy care**: can be given by a psychiatrist, a therapist or a mental health clinic that provides both services. It is not uncommon for an individual with emotional problems to see both a psychiatrist for medications and a therapist – who is usually a clinical psychologist or clinical social worker. Note that many therapists have early morning or late afternoon/evening appointments to accommodate working people.
- **Preventive care**: There is a fair amount of public discussion about the need for more preventive mental health services but little agreement as to what those services should be. Your insurance plans offer fairly comprehensive coverage for mental health counselling and people are encouraged to seek counselling for persistent feelings of depression, anxiety, or uncontrollable anger. Schools will often inform parents if they feel a child needs behavioural evaluation and/or counselling based on how he/she is functioning in the classroom.

How to find an in-network mental health professional or treatment facility:

Your network provider directory, which can be accessed online, has listings with contact numbers for "behavioural health providers." This is a good place to start as there is a benefit, as in other aspects of your care, to seeing an in-network provider. Your primary care physician may have suggestions for both talk therapy and psychopharmacologists, and some primary care physicians feel comfortable prescribing psychiatric medications themselves.

- **In-patient, residential and out-patient treatment for substance and/or alcohol abuse:** Most cases will be covered by your plan. There are many specialized facilities that treat drug and alcohol problems, a list of which is in the index as well as your provider network directory. Your primary care physician can generally help with a referral to a network facility.

Alternative Medical Practices

Coverage of alternative or naturopathic medical practices is limited to acupuncture, chiropractic services and nutritional counselling when you go to an in-net-work provider. Other practices such as homeopathy, massage therapy, nutritional supplements, and movement therapy are not covered services and generally will not be reimbursed.

Staff Counsellor's Office at UN Headquarters

The Staff Counsellor's Office (SCO) is a primary point of contact for UN staff members to receive support and professional counselling when facing crisis or personal concerns including stress, anxiety, depression, grief, burnout, substance abuse, relationship issues, or reaction to a traumatic event. The SCO offers short-term individual counselling sessions that are confidential and free of charge. If longer-term assistance is needed, the SCO can refer you to an external provider. The SCO delivers Psychological First Aid to staff and families requiring immediate psychological or emotional support. Also, the SCO offers a variety of workshops, with a strong focus placed on providing staff with the knowledge and skills to manage daily stress, crisis, and difficult situations for themselves, family members, and their colleagues. We encourage staff members and managers to utilize the wealth of resources available through our office.

Staff Counsellor's Office
UN Secretariat Building
5th Floor
New York, NY, 10017
Tel. +1 212 963 7044scohq@un.org

Health Insurance Portability and Accountability Act/ Patient Rights

The Health Insurance Portability and Accountability Act (HIPPA) was passed in 1996 to keep protected health information (PHI) private and allow patients to access their records. PHI includes any information that identifies an individual, such as their name or date of birth. In addition, all past, current, and future information on a patient's health condition or payment of such condition is to remain confidential. PHI may only be used for medical treatment, payment processing, healthcare business operations, research, and public health information required by law. Patients have the right to request to access their medical records at any time, or to authorize the release of their records to a specified third party. If you believe there has been a violation of patient privacy, you may file a complaint at OCR portal within 180 days of the event.

Patients have the right to file grievances with a hospital or medical practice if they believe their health care provider was practicing with gross incompetence or negligence, was impaired by drugs or alcohol, refused to provide services due to race, color or national origin, or filed a false report. You may file this grievance with the Office of Professional Medical Misconduct. All complaints are kept confidential.

Office of Professional Medical Misconduct
NYS Department of Health, Riverview Center
150 Broadway, Suite 355
Albany, New York 12204-2719
Phone: 518-402-0836 or 1-800-663-6114.

Additional Benefits of your UN Insurance Plan

Your Aetna and Empire Blue Cross coverage includes additional benefits for you whose costs are part of your monthly contributions.

Active Health

This program was implemented as a health management service that provides confidential disease management and wellness programs to Aetna and Empire Blue Cross plan participants. This program works to reduce preventable conditions, which are often precursors to more serious and chronic conditions. It provides important care considerations to participants and their doctors and assists in managing the health concerns of participants including through voluntary one-on-one nurse coaching for members with chronic conditions.

Additional details can be found in the latest information circular on the UN health insurance program available at the UN Health and Life Insurance Section website (un.org/insurance).

FrontierMedex

This program provides emergency medical assistance when you or your covered family members are 100 or more miles away from your residence. Such assistance includes arranging for emergency evacuation and repatriation especially when you are on personal travel. Additional details of this program can be found in the latest information circular on the UN health insurance program available at the UN Health and Life Insurance section (un.org/insurance). Please note that while evacuation and repatriation can be arranged, the related cost will not be covered by FrontierMedex, your health insurance plan, or the UN when it involves personal travel. Staff members may purchase travel insurance at their own cost that provides such coverage.

Appendix

Major Hospitals within 50 miles of United Nations Headquarters

Manhattan

NYU Hospitals Center Rusk
400 East 34th Street
New York, NY 10016
(212) 263-7300

NYU Hospitals Center Tisch
550 1st Avenue
New York, NY 10016
(212) 263-7300

Bellevue Hospital Center
462 First Avenue
New York, NY 10016
(212) 562-4141

Memorial Sloan Kettering Cancer Center
1275 York Avenue
New York, NY 10065
(212) 639-2000

Hospital for Special Surgery
535 East 70th Street
New York, NY 10021
(212) 606-1000

Lenox Hill Hospital
100 East 77th Street
New York, NY 10075
(212) 434-2000

Harlem Hospital Center
506 Lenox Avenue
New York, NY 10037
(212) 939-1000

NYU Hospitals Center HJD
301 East 17th Street
New York, NY 10003
(212) 598-6000

New York Eye and Ear Infirmary
310 East 14th Street
New York, NY 10003
(212) 979-4000

Beth Israel Medical Center-Petrie Division
1st Avenue & 16th Street
New York, NY 10003
(212) 420-2000

Metropolitan Hospital Center
1901 First Avenue
New York, NY 10029
(212) 423-6262

Mount Sinai Medical Center
1 Gustave L Levy Place
Box 300
New York, NY 10029
(212) 241-6500

St. Luke's-Roosevelt Hosp Ctr-St. Luke's Division
1111 Amsterdam Avenue
New York, NY 10025
(212) 523-4000

New York Presbyterian Hospital
The Allen Pavilion
5141 Broadway
New York, NY 10034
(212) 932-4000

New York Presbyterian Hospital Columbia Presbyterian Campus
622 West 168th Street
New York, NY 10032
(212) 305-2500

Bronx

Lincoln Hospital and Mental Health Center
234 East 149th Street
Bronx, NY 10451
(718) 579-5000

St. Barnabas Hospital
4422 Third Avenue
Bronx, NY 10457
(718) 960-9000

North Central Bronx Hospital
3424 Kossuth Avenue
Bronx, NY 10467
(718) 519-5000

Montefiore Medical Center/Henry & Lucy Moses Division
111 East 210th Street
Bronx, NY 10467
(718) 920-4321

Jacobi Medical Center
1400 Pelham Pkwy. South
Bronx, NY 10461
(718) 918-5000

Brooklyn

NYU Hospitals Center Tisch
1630 East 14th Street
Brooklyn, NY 11229
(718) 336-9100

Woodhull Medical and Mental Health Center
760 Broadway
Brooklyn, NY 11206
(718) 963-8000

Brooklyn Hospital Center-Downtown Campus
121 Dekalb Avenue
Brooklyn, NY 11201
(718) 250-8000

Wyckoff Heights Medical Center
374 Stockholm Street
Brooklyn, NY 11237
(718) 963-7272

New York Methodist Hospital
506 6th Street
Brooklyn, NY 11215
(718) 780-3000

Kingsbrook Jewish Medical Center
585 Schenectady Avenue
Brooklyn, NY 11203
(718) 604-5000

Kings County Hospital Center
451 Clarkson Avenue
Brooklyn, NY 11203
(718) 245-3131

Brookdale Hospital Medical Center
1 Brookdale Plaza
Brooklyn, NY 11212
(718) 240-5000

Lutheran Medical Center
150 55th Street
Brooklyn, NY 11220
(718) 630-7000

Maimonides Medical Center
4802 10th Avenue
Brooklyn, NY 11219
(718) 283-6000

Coney Island Hospital
2601 Ocean Pkwy.
Brooklyn, NY 11235
(718) 616-3000

Holy Name Hospital
718 Teaneck Road
Teaneck, NJ 07666
(201) 833-3000

Beth Israel Medical Center-Kings Highway Division
3201 Kings Hwy.
Brooklyn, NY 11234
(718) 252-3000

New York Community Hospital of Brooklyn
2525 Kings Hwy.
Brooklyn, NY 11229
(718) 692-5300

Queens

Mount Sinai Hospital of Queens
25-10 30th Avenue
Long Island City, NY 11102
(718) 932-1000

Elmhurst Hospital Center
79-01 Broadway
Elmhurst, NY 11373
(718) 334-4000

Flushing Hospital Medical Center
4500 Parsons Blvd.
Flushing, NY 11355
(718) 670-5000

New York Hospital Medical Center of Queens
5645 Main Street
Flushing, NY 11355
(718) 670-1231

Forest Hills Hospital
102-01 66th Road
Forest Hills, NY 11375
(718) 830-4000

Queens Hospital Center
82/68 164th Street
Jamaica, NY 11432
(718) 883-3000

Jamaica Hospital Medical Center
8900 Van Wyck Expressway
Jamaica, NY 11418
(718) 206-6000

St. John's Episcopal Hospital
South Shore Division
327 Beach 19th Street
Far Rockaway, NY 11691
(718) 869-7000

Hempstead

Franklin Hospital
900 Franklin Avenue
Valley Stream, NY 11580
(516) 256-6000

St. Joseph Hospital
4295 Hempstead Turnpike
Bethpage, NY 11714
(516) 579-6000

Westchester County

Dobbs Ferry Pavilion of St. Johns Riverside
128 Ashford Avenue
Dobbs Ferry, NY 10522
(914) 693-0700

Northern Westchester Hospital Center
400 East Main Street
Mt. Kisco, NY 10549
(914) 666-1200

Phelps Memorial Hospital Center
701 North Broadway
Sleepy Hollow, NY 10591
(914) 366-3000

Northern Westchester Hospital Center
400 East Main Street
Mt. Kisco, NY 10549

Westchester Medical Center
100 Woods Road
Valhalla, NY 10595
(914) 493-7000

White Plains Hospital Center
Davis Avenue at East Post Road
White Plains, NY 10601
(914) 681-0600

St. Joseph's Medical Center
127 South Broadway
Yonkers, NY 10701
(914) 378-7000

St. John's Riverside Hospital
967 North Broadway
Yonkers, NY 10701
(914) 964-4444

Lawren Hospital Center
55 Palmer Avenue
Bronxville, NY 10708
(914) 787-1000

Rockland County
Nyack Hospital
160 North Midland Avenue
Nyack, NY 10960
(845) 348-2000

Orange County
St. Anthony Community Hospital
15 Maple Avenue
Warwick, NY 10990
(845) 986-2276

Long Island
Long Island Jewish Medical Center
27005 76th Avenue
New Hyde Park, NY 11040
(718) 470-7000

North Shore University Hospital
300 Community Drive
Manhasset, NY 11030
(516) 562-0100

St. Francis Hospital/The Heart Center
100 Port Washington Blvd.
Roslyn, NY 11576
(516) 562-6000

Winthrop-University Hospital
259 1st Street
Mineola, NY 11501
(516) 663-0333

Mercy Medical Center
1000 North Village Avenue
Rockville Centre, NY 11570
(516) 705-2525

South Nassau Communities Hospital
1 Healthy Way
Oceanside, NY 11572
(516) 632-3000

Long Beach Medical Center
455 East Bay Drive
Long Beach, NY 11561
(516) 897-1000

Glen Cove Hospital
101 St. Andrews Lane
Glen Cove, NY 11542
(516) 674-7300

Syosset Hospital
221 Jericho Tpke.
Syosset, NY 11791
(516) 496-6400

Montefiore New Rochelle Hospital
16 Guion Place
New Rochelle, NY 10801
(914) 632-5000

Plainview Hospital
888 Old Country Road
Plainview, NY 11803
(516) 719-3000

Good Samaritan Hospital
255 LaFayette Avenue
Suffern, NY 10901
(845) 368-5000

Huntington Hospital
270 Park Avenue
Huntington, NY 11743
(631) 351-2000

Hudson Valley Hospital Center
1980 Crompond Road
Cortlandt Manor, NY 10567
(914) 737-9000

Good Samaritan Hospital Medical Center
1000 Montauk Hwy.
West Islip, NY 11795
(631) 376-3000

Southside Hospital
301 East Main Street
Bay Shore, NY 11706
(631) 968-3000

St. Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787
(631) 862-3000

Staten Island
Richmond University Medical Center
355 Bard Avenue
Staten Island, NY 10310
(718) 818-1234

Staten Island University Hospital-North Site
475 Seaview Avenue
Staten Island, NY 10305
(718) 226-9000

New Jersey
Newark Beth Israel Medical Center
201 Lyons Avenue
Newark, NJ 07112
(973) 926-7000

Meadowlands Hospital Medical Center
55 Meadowlands Pkwy.
Secaucus, NJ 07094
(201) 392-3100

Hackensack University Medical Center
30 Prospect Avenue
Hackensack, NJ 07601
(201) 996-2000

Hackensack University Medical Center at Pascack Valley
250 Old Hook Road
Westwood, NJ 07675
(201) 880-2700

Montclair Hospital, LLC
Hackensack UMC Mountainside
1 Bay Avenue
Montclair, NJ 07042
(973) 429-6000

Englewood Hospital & Medical Center
350 Engle Street
Englewood, NJ 07631
(201) 894-3000

Clara Maass Medical Center
1 Clara Maass Drive
Belleville, NJ 07109
(973) 450-2000

St. Mary's Hospital/Passaic
350 Blvd.
Passaic, NJ 07055
(973) 365-4300

Valley Hospital
223 North Van Dien Avenue
Ridgewood, NJ 07450
(201) 447-8000

East Orange General Hospital
300 Central Avenue
East Orange, NJ 07018
(973) 672-8400

Overlook Medical Center
99 Beauvoir Avenue
Summit, NJ 07901
(908) 522-2000

Saint Barnabas Medical Center
94 Old Short Hills Road
Livingston, NJ 07039
(973) 322-5000

St. Joseph's Wayne Hospital
224 Hamburg Tpke
Wayne, NJ 07470
(973) 942-6900

Chilton Medical Center
97 West Pkwy.
Pompton Plains, NJ 07444
(973) 831-5000

John F Kennedy Medical Center
65 James Street
Edison, NJ 08820
(732) 321-7000

Robert Wood Johnson University Hospital at Rahway
865 Stone Street
Rahway, NJ 07065
(732) 381-4200

Robert Wood Johnson University Hospital
1 Robert Wood Johnson Place
New Brunswick, NJ 08901
(732) 828-3000

Morristown Medical Center
100 Madison Avenue
Morristown, NJ 07960
(973) 971-5000

Saint Clare's Hospital/Denville/Dover
25 Pocono Road
Denville, NJ 07834
(973) 625-6000

Riverview Medical Center
1 Riverview Plaza
Red Bank, NJ 07701
(732) 741-2700

Somerset Medical Center
110 Rehill Avenue
Somerville, NJ 08876
(908) 685-2200

Saint Peter's University Hospital
254 Easton Avenue
New Brunswick, NJ 08901
(732) 745-8600

Monmouth Medical Center
300 2nd Avenue
Long Branch, NJ 07740
(732) 222-5200

Saint Clare's Hospital/Denville/Dover
400 West Blackwell Street
Dover, NJ 07801
(973) 989-3000

Bayshore Community Hospital
727 North Beers Street
Holmdel, NJ 07733
(732) 739-5900

Centrastate Medical Center
901 West Main Street
Freehold, NJ 07728

Connecticut
Greenwich Hospital
5 Perryridge Road
Greenwich, CT 06830
(203) 863-3000

Stamford Hospital
30 Shelburne Road
Stamford, CT 06902
(203) 325-7000

Resources for Hospitals in NJ, PA, CT and DE:

New Jersey:
American Hospitals Directory
http://www.ahd.com/states/hospital_NJ.html

Pennsylvania:
Pennsylvania Department of Health, Hospital name address book
http://apps.health.state.pa.us/...

Connecticut:
State of Connecticut, Department of Public Health
http://www.ct.gov/...

Delaware:
State of Delaware Health and Social Services
http://...

Psychiatric Emergency Room Care in New York City[2]

Hospital Name	Phone / Address	Types of Facility	Accepts Involuntary Admission
Bellevue Hospital Center: Comprehensive Psychiatric Emergency Program (CPEP)	462 First Avenue New York, NY 10016 (212) 562-4678	Emergency Care for adults age 18+	
Bronx Lebanon Hospital: Comprehensive Psychiatric Emergency Program (CPEP)	1276 Fulton Avenue Bronx, NY 10456 (718) 901-8222	Emergency Care for anyone age 5+	
Brookdale Hospital: Comprehensive Psychiatric Emergency Program (CPEP)	1 Brookdale Plaza Brooklyn, NY 11212 (718) 240-5762	Emergency Care for anyone age 5+	
Coney Island Hospital: Psychiatric Emergency Room	2601 Ocean Parkway Brooklyn, NY 11235 (718) 319-3374	Emergency Care	Yes
Elmhurst Hospital: Comprehensive Psychiatric Emergency Program (CPEP)	79-01 Broadway Elmhurst, NY 11373 (718) 334-3675	Emergency Care for anyone age 5+	Yes
Flushing Hospital Medical Center: Emergency Room	4500 Parsons Blvd Flushing, NY 11355 (718) 670-5494	No Emergency Care; refer clients to the regular ER	
Harlem Hospital: Comprehensive Psychiatric Emergency Program (CPEP)	506 Lenox Avenue New York, NY 10037 (212) 939-3325	Emergency Care for anyone age 18+	Yes
Jacobi Medical Center: Comprehensive Psychiatric Emergency Program (CPEP)	1400 Pelham Pkwy South Bronx, NY 10461 (718) 918-4850	Emergency Care for anyone age 18+	Yes
Jamaica Hospital Medical Center: Psychiatric Emergency Room	8900 Van Wyck Expressway Jamaica, NY 11418 (718) 206-7099	Emergency Care 24/7 for adults 18+	Yes
Kings County Hospital: Comprehensive Psychiatric Emergency Program (CPEP)	410 Winthrop Street Brooklyn, NY 11203 (718) 245-2727 or (718) 245-2718	Emergency Care	Yes
Lenox Hill Hospital: Psychiatric Emergency	77th & Park Ave. New York, NY 10021 (212) 434-3030	Emergency Care	

[2] Reference:

Lincoln Medical & Mental Health Center: Psychiatric Emergency Room	234 E. 149th St. Bronx, NY 10451 (718) 579-3287	Emergency Care	Yes
Lutheran Medical Center: Psychiatric Emergency Room	150 55th Street Brooklyn, NY 11220 (718) 630-6566	Emergency Care 24/7 for anyone 1[illegible]+	
Maimonides Medical Center: Psychiatric Emergency Room	4802 10th Ave Brooklyn, NY 11219 (718) 283-1404	Emergency Care 24/7 for anyone 18+	
Metropolitan Hospital Center: Psychiatric Emergency Room	1901 First Avenue New York, NY 10029 (212) 423-7312	Emergency Care serving individuals of all ages	
Montefiore Medical Center: Emergency Room	111 East 210th Street Bronx, NY 10467 (718) 920-7460	Emergency Care	
Montefiore Medical Center: The North Division: Emergency Room	600 E 233rd Street Bronx, NY 10466 (718) 920-9177	Emergency Care	Yes
Mount Sinai Medical Center: Psychiatric Emergency Room	1468 Madison Avenue New York, NY 10029 (212) 241-7147	Emergency Care	Yes
New York Presbyterian - Weill Cornell Medical College: Psychiatric Emergency Room	525 East 68th Street Manhattan, NY 10021 (212) 746-0711	Emergency Care for anyone age 21+	Yes
North Central Bronx Hospital: Psychiatric Emergency Room	3424 Kossuth Avenue Bronx, NY 10467 (718) 519-3030	Emergency Care	Yes
North Shore-Long Island Jewish Health System: The Zucker Hillside Hospital: Psychiatric Emergency Room	270-05 76th Avenue New Hyde Park, NY 11040 (718) 470-7500	Emergency Care for anyone [illegible]ge 18+	Yes
Queens Hospital Center: Comprehensive Psychiatric Emergency Program (CPEP)	82-68 164th Street Jamaica, NY 11432 (718) 883-3575	Emergency Care for anyone age 18+	Yes
Richmond University Medical Center: Comprehensive Psychiatric Emergency Program (CPEP)	75 Vanderbilt Avenue Staten Island, NY 10304 (718) 818-6300	Emergency Care; Substance Abuse Crisis	
St. Barnabas Hospital: Emergency Room	4422 Third Avenue Bronx, NY 10457 (718) 960-6117	Emergency Care	Yes
St. John's Episcopal Hospital: Psychiatric Emergency Room	327 Beach 19th Street Far Rockaway, NY 11691 (718) 869-7755	Emergency Care for anyone in Queens	Yes

St. Luke's Roosevelt Hospital: Comprehensive Psychiatric Emergency Program (CPEP) Roosevelt Location	1000 10th Ave New York, NY 10019 (212) 523-6775 or (212) 523-6491	Emergency Care for anyone age 18+; Substance Abuse Crisis	Yes
St. Luke's Roosevelt Hospital: Comprehensive Psychiatric Emergency Program (CPEP) St. Luke's	1111 Amsterdam Ave New York, NY 10025 (212) 523-5849	Emergency Care for anyone age 18+	Yes
Staten Island University Hospital: Emergency Room	375 Seguine Ave. Staten Island, NY 10309 (718) 226-2100	NOT Emergency Care	Yes
Woodhull Hospital: Psychiatric Emergency Room	760 Broadway Brooklyn, NY 11206 (718) 963-8439	Emergency Care for anyone age 18+	Yes
Hazelden New York Outpatient Services	322 8th Avenue New York, NY 10001 (212) 420-9520	Substance Abuse Crisis	
Cornell University Midtown Center for Treatment and Research	56 West 45th Street 9th Floor New York, NY 10036 Intake: (212) 764-5178 (212) 764-5178 ×11	Substance Abuse Crisis	
Realization Center Inc./Medically Supervised Ambulatory Chem Depend	19 Union Square West 7th Floor New York, NY 10003 (212) 627-9600	Substance Abuse Crisis	

Patient Bill of Rights

As a patient in a hospital in New York State, you have the right, consistent with law, to:

(1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
(2) Receive treatment without discrimination as to race, colour, religion, sex, national origin, disability, sexual orientation, source of payment, or age.
(3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
(4) Receive emergency care if you need it.
(5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
(6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
(7) A no smoking room.
(8) Receive complete information about your diagnosis, treatment and prognosis.
(9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."
(11) Refuse treatment and be told what effect this may have on your health.
(12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
(13) Privacy while in the hospital and confidentiality of all information and records regarding your care.
(14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
(15) Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
(16) Receive an itemized bill and explanation of all charges.
(17) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.
(18) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
(19) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

Public Health Law(PHL)2803 (1)(g) Patient's Rights. 10NYCRR. 405.7 405.7(a)(1) 405.7(c)

Handbook Acknowledgments

I want to express my deepest gratitude to all involved in the development of the Handbook. This was a collective work of numerous UN and non-UN colleagues, all of whom were committed to making it user-friendly and responsive to the needs of UN personnel and their family.

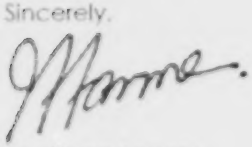
The initial draft of this Handbook was prepared for the UN Medical Services Division (MSD) by Dr. Susan Massad, a general medicine doctor based in New York with over 40 years of medical experience.

Contributors from the Medical Services Division include Dr. Michael Rowell, who first suggested the idea of this Handbook; James Gibson and Dr. Abdalla Mansour Amer who provided valuable feedback to the document; and Dr. Esther Tan, who coordinated the overall review of the draft by relevant parties.

Special thanks and appreciation are given to staff from the UN Health and Life Insurance Division for their important contributions to the Handbook on insurance-related matters; the OHRM Communications team on the design and dissemination of the Handbook; and the New York Local Expatriate Spouse Association (NYLESA) for their review of the document.

Finally, MSD gratefully acknowledges all staff of the UN for their valuable feedback to this document. We truly hope that this tool will be useful and provide you and your family with the necessary guidance and resources needed to navigate the US health care system.

Sincerely,



Dr. Jillann Farmer
Medical Director
UN Medical Services Division